

08570

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKS</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XI ROCKS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bertha Julia Amos</u>				4. DATE OF DEATH Month Day Year <u>August 19 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 27 1877</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not Known</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs Wm Crockett, Rocks Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>331X</u> (a), stating the underlying cause lost. DUE TO (c) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>None</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-19-57</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Md	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 21 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Street Hartford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm M Knut, Janesville</u>				24a. REC'D BY REGISTRAR DATE <u>8-23-57</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATES OF DEATH

BUREAU V. S.

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar pending to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

08546

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08551

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen,		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R D 1 Port Deposit 07x2.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mt. Royal Ave.				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Lee Campbell				4. DATE OF DEATH Month August Day 15 Year 19 57			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-28-06	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 50 Hours 50 Min.		IF UNDER 24 HRS. Hours 50 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY contractor		11. BIRTHPLACE (State or foreign country) Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter C. Campbell				14. MOTHER'S MAIDEN NAME Bessie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 220-18-7202		17. INFORMANT Ethel Campbell, Port Deposit, Md. RD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 coronary occlusion DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-18-1957		22c. NAME OF CEMETERY OR CREMATORY Asbury	
22d. LOCATION (City, town, or county) (State) Port Deposit, Md. RD 1							
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.				24a. REC'D BY REGISTRAR Aug 16/57		24b. REGISTRAR'S SIGNATURE Ellie G. Perry	

MINNESOTA STATE DEPARTMENT OF HEALTH - BALTICORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08552

08547

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New York</u> b. COUNTY <u>Brooklyn</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Grace, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u> 69x3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>267 Bay 43rd St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Chandler</u> Last <u>Chandler</u>				4. DATE OF DEATH Month <u>8</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3 1883</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Refinery & Trade Shop</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. J. Chandler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT <u>Mrs. Olga Diamantopolis</u> Address <u>122 Ocean Dr. Harold Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> <u>422.1</u> DUE TO <u>disease with Cardiac decompensation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sation</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic bronchitis & pneumonitis - bilateral</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>492x</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m.				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 16th, 1957</u> to <u>Aug. 23rd, 1957</u> , that I last saw the deceased alive on <u>Aug. 23rd, 1957</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, and state) <u>241 N. Union Ave. Harold Grace, Ind.</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				DATE SIGNED <u>8/23/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harold Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Grace, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>8-26-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis, Md.</u>			

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - DIVISION 10

BUREAU V. S.

AUG 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08553

08548

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>93 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>UNIATA 830 JEFFERSON ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>-</u> Last <u>DOMINICK</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13-1868</u> 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MARRIED NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Samuel Dominick, Harford, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive metastasis in the abdomen</u> <u>153X</u> DUE TO <u>adenocarcinoma of the colon (Two lesions)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-1</u> , 19 <u>57</u> , to <u>8-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11 PM</u> , 19 <u>57</u> , and that death occurred at <u>12:01 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry H. Kwak</u> M.D.				ADDRESS (Street, city or town, state) <u>Harford Mem. Hospital, Harford, Md.</u> DATE SIGNED <u>8-1-57</u>			
PHYSICIAN'S NAME (Type) <u>HENRY H. KWAK</u>				HARFORD MEMORIAL HOSP.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Dominick</u> ADDRESS <u>Harford, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-2-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

AUG 5 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08549

CERTIFICATE OF DEATH

Reg. Dist. No.

08554

185

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hernesda Race</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ed #2 07X1.2</u>	
c. LENGTH OF STAY IN 15 <u>6 days</u>		d. STREET ADDRESS <u>Rising Sun</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Baltimore Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard J. Durham</u>		4. DATE OF DEATH Month Day Year <u>August 27 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/1902</u>
9. AGE (In years last birthday) <u>55 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Foreman U.S. Government</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steam Boiler</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Durham</u>		14. MOTHER'S MAIDEN NAME <u>Larsh Tucherer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>183-05-5937</u>	
17. INFORMANT <u>Mrs. Katherine Durham Rising Sun, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Posterior lateral Coronary thrombosis 6 days</u> with myocardial infarction (b) <u>Arteriosclerotic Cardiovascular</u> disease DUE TO <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombophlebitis - right lower extremity</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 22nd 1957</u> to <u>Aug 27th 1957</u> that I last saw the deceased alive on <u>Aug 27th 1957</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Too, M.D.</u>		ADDRESS (Street, city or town, state) <u>211 N. Union Ave. Rising Sun, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u>		DATE SIGNED <u>8/27/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 31/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cr. Rising Sun, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Tyson, Rising Sun, Md.</u>		ADDRESS <u>30157</u>	
24a. REC'D BY REGISTRAR <u>Dr. L. Lewis</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU OF VITAL RECORDS

MAY 30 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08550
CERTIFICATE OF DEATH

08555

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland COUNTY Harford Dall			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace Dallas	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital				d. STREET ADDRESS 7626 Hilliard Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James		First Tyler		Middle Erwin		Last	
4. DATE OF DEATH August		Month		Day 6		Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 6, 1957		9. AGE (In years last birthday) yrs. 9 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Travis Herman Erwin				14. MOTHER'S MAIDEN NAME Priscilla Anne Hahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Father		Address As in 2 above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 6 , 19 57 , to August 6 , 19 57 , that I last saw the deceased alive on _____, 19____, and that death occurred at 9:45P M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aberdeen Proving Ground, Maryland DATE SIGNED August 6 1957							
ACTUAL SIGNATURE George C. Santos		M.D. US Army Hospital					
PHYSICIAN'S NAME (Type) GEORGE C. SANTOS, CAPT, MC.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 9th 1957		22c. NAME OF CEMETERY OR CREMATORY Post Cemetery		22d. LOCATION (City, town, or county) (State) Aberdeen Proving G. Md	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Sarfing				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE Aug 12-57	
				24b. REGISTRAR'S SIGNATURE Marie G. Gray			

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 171X41

BUREAU V. S.

MAY 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08551

CERTIFICATE OF DEATH

08556-

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>802 Harfield Rd</u>	
3. NAME OF DECEASED (Type or print) <u>RICHARD First Calver Middlest Baby Boy Gamble (#2)</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1957</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Clifton Gamble</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Giles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Robert C. Gamble</u>		Address <u>802 Harfield Rd. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY</u> <u>762.5</u> DUE TO <u>POLYHYDRAMNIOS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PULMONARY ATLECTASIS</u> (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost the deceased alive on <u>August 4</u> , 19 <u>57</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Frank Wolbert</u> M.D. <u>200 NORTH UNION AVE</u> <u>8/4/57</u> PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT MD</u> <u>HARRE DE GRACE MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-5-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Meth Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chesapeake Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles G. Bullock</u>		ADDRESS <u>Harre de Grace, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>8-5-57</u>
		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m. l.</u>	

RECEIVED

AUG 7 1957

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08552

CERTIFICATE OF DEATH

08552

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>802 Garfield Road</u>	
3. NAME OF DECEASED (Type or print) <u>Russell</u> First <u>Calvin</u> Middle <u>Boyd</u> Last <u>Samble</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-4-57</u>
9. AGE (In years last birthday) yrs. <u>9</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Robert Samble</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mae Giles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Robert Samble - Father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURITY & PULMONARY ATALACTASIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POLYHYDRAMNIOS</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>Aug. 4</u> , 19 <u>57</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Wolbert</u> M.D.		ADDRESS (Street, city or town, state) <u>200 NORTH VANCE AVE</u> DATE SIGNED <u>AUGUST 4, 1957</u>	
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT M.D.</u>		<u>HARRE DE GRACE MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Mt. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Buller</u>		ADDRESS <u>Harre de Grace, Md.</u>	
24a. REC'D BY REGISTRAR <u>8-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for use as the burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08553

CERTIFICATE OF DEATH

08558

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>			d. STREET ADDRESS <u>546 Locust St.</u>		
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Grimes</u> Last <u>Grimes</u>			4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1957</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1924</u>		9. AGE (In years last birthday) <u>33</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Neely's Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Firework Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Harve de Grace</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>William Grimes</u>		
14. MOTHER'S MAIDEN NAME <u>Florence Jones</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>220-22-6730</u>			17. INFORMANT <u>Mrs. Florence Grimes - Harve de Grace Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>54</u> , to <u>8/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>57</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>George J. Stansbury</u>		ADDRESS (Street, city or town, state) <u>549 Revolution St. Harve de Grace, Md.</u>			
DATE SIGNED <u>8/24/57</u>					
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		ADDRESS <u>Harve de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-27-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. James G.M.E. Cemetery</u>	22d. LOCATION (City, town, or county)	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Attilio J. Bullock - Harve de Grace Md</u>		ADDRESS	24a. REC'D BY REGISTRAR <u>G. L. Lewis M.D.</u>	24b. REGISTRAR'S SIGNATURE	
DATE <u>8-26-57</u>					

RECEIVED

AUG 23 1955

BUREAU V. S.

08554

CERTIFICATE OF DEATH

Reg. Dist. No.

0855485

1. PLACE OF DEATH a. COUNTY <u>HARTFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARRE-DE-GRAVE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RISING SUN RURAL</u>	
c. LENGTH OF STAY IN 1b <u>30 hrs.</u>		d. STREET ADDRESS <u>111</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARTFORD MEMORIAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard Hamilton Guthrie</u>		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1926</u>
9. AGE (In years lost birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Press Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fiber Mill</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Warren Smith</u>		14. MOTHER'S MAIDEN NAME <u>Iva Mae Bollen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>417-40-416</u>	
17. INFORMANT <u>Sis Guthrie</u>		Address <u>Rising Sun, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X</u> DUE TO <u>Rheumatic Heart Disease</u> <u>Pulmonary Edema</u> <u>Severe Mitral Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>410X</u> (c) <u>Severe Mitral Stenosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u> <u>3 days</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>8/4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/4</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u>		DATE SIGNED <u>8/6/57</u>	
PHYSICIAN'S NAME (Type) <u>Neil Taylor Jr.</u>		ADDRESS (Street, city or town, state) <u>Rising Sun, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 7, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Friends Burial Ground</u>	22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Sykes</u>		24a. REC'D BY REGISTRAR <u>Dr. A. L. Lewis</u>	
ADDRESS <u>Rising Sun, Md.</u>		DATE <u>Aug 7, 1957</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. S.

08571

CERTIFICATE OF DEATH

08560

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Macdonna (Rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rutledge, Fallston RD</u>			
c. LENGTH OF STAY IN 1b <u>3 days</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>Katherine</u> Last <u>Hanlon</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31, 1892</u>		9. AGE (In years last birthday) <u>65 yrs</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>		11. BIRTHPLACE (State or foreign country) <u>Rutledge Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Hanlon</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Dalton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>-78-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>George L. Hanlon Fallston RD Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY occlusion.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY sclerosis.</u> (c) <u>HYPERTENSIVE-ARTERIOSCLEROTIC Heart Disease.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>18 Hours</u> <u>5 years</u> <u>20 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac Enlargement.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>57</u> , to <u>8/24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/24</u> , 19 <u>57</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. James Thomison, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Janettsville, Maryland.</u>			
PHYSICIAN'S NAME (Type) <u>S. JAMES THOMISON, JR., M.D.</u>				DATE SIGNED <u>Janettsville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 28, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Hyde Park Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin E. Ruth Janettsville</u>				24a. REC'D BY REGISTRAR <u>DATE 8-28-57</u>		24b. REGISTRAR'S SIGNATURE <u>Barilla forward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. I.

JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08555

CERTIFICATE OF DEATH

Reg. Dist. No.

08561

185-

1. PLACE OF DEATH a. COUNTY <u>Harpard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harpard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Larue de Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Larue de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harpard Memorial Hospital</u>				d. STREET ADDRESS <u>510 Jerritta St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary Ellen</u> Middle <u>Harpard</u> Last <u>Harpard</u>				4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/1894</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland - North East</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Wharton - ? deceased</u>				14. MOTHER'S M maiden name <u>(deceased)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO <u> </u>			
17. INFORMANT <u>Howard H. Hawtcher - Harrods Grace, Mo.</u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute cardiac failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>August 5</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 5</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Simon</u> M.D.				DATE SIGNED <u>August 5, 1957</u>			
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>				ADDRESS (Street, city or town, state) <u>Harpard de Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-8-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North East Meth. Co.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecil Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Madison Mitchell</u>				ADDRESS <u>Harpard de Grace, Mo.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>8-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. H. Lewis m. al.</u>			

RECEIVED

JUG 9 1957

RECEIVED

08556

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY Hartford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Md b. COUNTY Hartford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartford		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Hartford Memorial Hospital		d. STREET ADDRESS 35 GROVE ST	
3. NAME OF DECEASED (Type or print) William Harry First Middle Last Hoke		4. DATE OF DEATH August 10 19 57 Month Day Year	
5. SEX M	6. COLOR OR RACE E	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 October 1915 9. AGE (In years to birthday) 41 1/2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Banks		14. MOTHER'S MAIDEN NAME Rachel Hoke	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT William H. Banks		Address 35 Grove St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to DUE TO Crushing Injury Pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> Auto accident auto-bicycle type		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 8-10-57 Hour 11 a. m. — p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) New County Rd	20f. (City or town) Aberdeen (County) Hartford (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald E Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald E Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY Asbury	22d. LOCATION (City, town, or county) Churchville (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John G. Harving		24a. REC'D BY REGISTRAR — 24b. REGISTRAR'S SIGNATURE G. L. Lewis	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

UG 14 1957

RECEIVED

08557

CERTIFICATE OF DEATH

08563

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sunnyside Grace</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarkington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type and print) First <u>Elyahut</u> Middle <u>J.</u> Last <u>Hutchinson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 13, 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u>		IF UNDER 24 HRS Hours <u>17</u> Min <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>James Kowalsky</u>				14. MOTHER'S MAIDEN NAME <u>Lathyn Kowal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Mrs M. L. Hutchinson</u> Address <u>Clarkington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO <u>Common Duct "T"-tube drainage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Cholecystectomy and Cholelithotomy for gangrenous cholecystitis</u> (b) <u>Cholecystectomy and Cholelithotomy</u> (c) <u>for gangrenous cholecystitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>17 days</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8 Aug</u> , 19 <u>57</u> , to <u>26 Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>26 Aug</u> , 19 <u>57</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6005 Union Av.</u> DATE SIGNED <u>26 Aug '57</u>							
ACTUAL SIGNATURE <u>W. H. Sadowsky</u> M.D.				NAME OF DECEASED <u>W. H. Sadowsky</u>			
PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY</u>				DATE <u>26 Aug '57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Buried</u>		<u>Aug 28, 1957</u>		<u>Brandywine</u>		<u>Clarkington, Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>				ADDRESS <u>Clarkington, Md.</u>		24a. REC'D BY REGISTRAR <u>E. L. Kirk</u>	
						24b. REGISTRAR'S SIGNATURE <u>Dr. L. L. Loring</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 6 1957

BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08564

Reg. Dist. No. 18

08572

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLSTON</u>				c. LENGTH OF STAY IN 1b <u>OVER 10 YRS</u> X <u>FALLSTON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RECKORD Rd</u>				d. STREET ADDRESS <u>RECKORD Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>DELBERT ROBERT JENNINGS</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 29 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUGUST 19, 1909</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BULL DOZER OPERATOR</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES M. JENNINGS</u>				14. MOTHER'S MAIDEN NAME <u>MARY MATILDA HAMPTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>GENE JENNINGS, FALLSTON, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL CONCUSSION</u> ESTIMATE <u>LESS THAN 1 HOUR</u> 81" X DUE TO (b) <u>CRUSHING INJURY TO HEAD FROM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>KNOCK-DOWN ON PAVEMENT BY AUTOMOBILE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>BEHAVE TO</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>HAVE BEEN BACKED OVER AND KNOCKED DOWN BY AUTO</u>					
20c. TIME OF INJURY Month, Day, Year <u>12:30 a.m. AUG 29 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>FALLSTON HARFORD Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 31, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>		22d. LOCATION (City, town, or county) (State) <u>BELAIR HARFORD, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Benson</u>				ADDRESS <u>BENSON, Md</u>			
				24a. REC'D BY REGISTRAR - <u>SEP 4 1957</u> REGISTRAR'S SIGNATURE <u>Marcella Howard</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 7 1967

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08573

CERTIFICATE OF DEATH

Reg. Dist. No.

48565
08565
181

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural HAYRE DE GRACE				c. LENGTH OF STAY IN 1b 27 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rural HAYRE DE GRACE X1			
3. NAME OF DECEASED (Type or print) JOHN First PAYMOND Middle MC Last ROBERTS				4. DATE OF DEATH 7-AUG- Month 1957 Day Year			
5 SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 MAR. 1907	
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER				10b. KIND OF BUSINESS OR INDUSTRY A.P.M.		11. BIRTHPLACE (State or foreign country) V.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John MCROBERTS				14. MOTHER'S MAIDEN NAME NANNIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Emma H. Roberts - Harford Grace Md #2		Address R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema - 251X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Massive Cerebral Hemorrhage - DUE TO (c) Malignant Hypertension						INTERVAL BETWEEN ONSET AND DEATH 2 hrs - 2 hrs - 10 years -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from May , 194 4 , to Aug 7 , 19 57 , that I last saw the deceased alive on August 7 , 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Robert M.D.				ADDRESS (Street, city or town, state) 200 North Ann Ave. Harford Md			
PHYSICIAN'S NAME (Type) FRANK WOLBERT M.D.				DATE SIGNED 8/7/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-AUG-1957		22c. NAME OF CEMETERY OR CREMATORY BEL AIR MEMORIAL		22d. LOCATION (City, town, or county) (State) BEL AIR MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS Harford Grace Md.		24a. REC'D BY REGISTRAR DATE Aug 9 57	
				24b. REGISTRAR'S SIGNATURE Hellie K. Lamy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 12 1957

BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08558

CERTIFICATE OF DEATH

08566

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>45 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NO</u>				d. STREET ADDRESS <u>115 S. Adams</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FAYE</u> Middle <u>ALGER</u> Last <u>MOTT</u>			4. DATE OF DEATH Month <u>AUG</u> Day <u>19</u> Year <u>1957</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 21 1901</u>		9. AGE (In years last birthday) <u>56</u> yrs	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>WEST CHESTER Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Hippie</u>			14. MOTHER'S MAIDEN NAME <u>ANNA L. CHANEY</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NONE</u>		17. INFORMANT Address <u>W. RAY MOTT 115 S. Adams St.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion - carcinoma</u> <u>175X</u> DUE TO <u>day - carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>
20c. TIME OF INJURY Hour a. g. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>8-18-57</u> to <u>8-21-57</u> , that I last saw the deceased alive on <u>8-21-57</u> , and that death occurred at <u>5-12 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>HAVERDE GRACE, MD.</u>				DATE SIGNED <u>8-21-57</u>			
PHYSICIAN'S NAME (Type) <u>A. L. Lewis</u>				ADDRESS (Street, city or town, state) <u>HAVERDE GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 22 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HAVERDE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				24a. REC'D BY REGISTRAR DATE <u>8-21-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis M.D.</u>	

RECEIVED

AUG 1 1957

BUREAU V. S.

08559

CERTIFICATE OF DEATH

Reg. Dist. No.

183-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE 20425</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>317 S. Union Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>LOUISE</u> Middle <u>MURPHY</u> Last <u>MURPHY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>44 80</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None Home Wife</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Witzel</u>		14. MOTHER'S MAIDEN NAME <u>Anna D. Voelke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Edward G. Murphy</u>		Address <u>317 S. Union Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive and arteriosclerotic</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiovascular disease</u> DUE TO (c) <u>443X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> , to <u>8/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7/31</u> , 19 <u>57</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>317 S. Union Ave</u> DATE SIGNED <u>8/1/57</u>			
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.		PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D. Haver de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Evin</u>	22d. LOCATION (City, town, or county) (State) <u>Harford County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin H. Haver de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-2-57</u>	24b. REGISTRAR'S SIGNATURE <u>A. X. K... m.d.</u>

TO HOSPITAL ■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 2 1917

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 221 10-23-57 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

08568

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u>	c. LENGTH OF STAY IN 1b <u>13 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1219 Freedom St.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Berema Ridout Pinion</u> First Middle Last		4. DATE OF DEATH <u>8/28/57</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/8/1918</u> 39 yrs.
9. AGE (In years last birthday) <u>39</u>		10. IF UNDER 1 YEAR: Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bozman Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Ridout</u>		14. MOTHER'S MAIDEN NAME <u>Delwa Brooks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Laurence Pinion</u>		Address <u>219 Freedom St. Harold Chase Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Cirrhosis of Liver</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6-7 mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/2</u> , 1951, to <u>8/28</u> , 1957, that I last saw the deceased alive on <u>8/28</u> , 1957, and that death occurred at <u>9:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George T. Stansbury</u> , M.D.		ADDRESS (Street, city or town, state) <u>529 Revolution St, Harrede Grace, Md.</u>	
DATE SIGNED <u>8/29/57</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		<u>529 Revolution St, Harrede Grace, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/31/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Catburg</u>	22d. LOCATION (City, town, or county) (State) <u>Bozman Hunt Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Conington Rm Harold Chase, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>8-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

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SEP 3 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)
SM 9/55

08561

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08569

Reg. Dist. No. 183-

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>N.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAYNE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>TRANSIENT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM ROBERT POPE</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 4 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 26, 1931</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Durham N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J.B. Pope</u>		14. MOTHER'S MAIDEN NAME <u>Rwannie Richards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>J.B. Pope</u>		Address <u>Qt. 1 - Macc N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY CHEST, ABDOMEN</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AND LOWER EXTREMITIES & COMPOUND</u> DUE TO (c) <u>COMMUNUTED FRACTURE LT LEG</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>CRUSHED BETWEEN PARKED AND MOVING CAR</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:15 a.m. AUG 4 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>HIGHWAY</u>		20f. (City or town) (County) (State) <u>BELCAMP HARFORD MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Philip W. Newman</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip W. Newman</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/6/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>		22d. LOCATION (City, town, or county) (State) <u>White Co N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barry H. Jr. Howard</u>		ADDRESS <u>Howard</u>	
24a. REC'D BY REGISTRAR <u>8-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>A. R. Remondell</u>	

TAU V. S.

1967

RECEIVED

Items 18-21 Filed 2/19/57

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08563

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u> Md. </u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abertdeen</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abertdeen</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Osbornes Lane</u>		d. STREET ADDRESS <u>Osbornes Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Beverly G. Quickley</u>		4. DATE OF DEATH <u>August 25</u> 1957	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/1936</u>
9. AGE (in years last birthday) <u>21</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>England Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles J. Reunion</u>	
14. MOTHER'S MAIDEN NAME <u>Beatrice Banks</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Charles J. Reunion</u> Address <u>Osbornes Lane Abertdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending Toxicology</u> <u>970.2</u> DUE TO <u>Examination</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Poisoning due to barbitol derivations</u> (c) <u>(nembutal)</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Depressed & took bottle nembutal capsules</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-25-57</u> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Osbornes Lane Harford Abertdeen</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		8-25-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Swan Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Harold Chase</u> ADDRESS <u>Harford Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8-26-57</u>	24b. REGISTRAR'S SIGNATURE <u>G. R. Lewis</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

AUG 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08571

08562

CERTIFICATE OF DEATH

Reg. Dist. No.

186

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>17 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>				e. STREET ADDRESS <u>ABERDEEN OLD POST ROAD - R.F.D. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>JOSHUA</u> Middle <u>ALBERT</u> Last <u>QUICKLEY</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 5, 1934</u>	
9. AGE (In years last birthday) <u>23</u> yrs.		10. FUND 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Aberdeen Proving Ground</u>			
13. FATHER'S NAME <u>JOSHUA QUICKLEY, SR.</u>				14. MOTHER'S MAIDEN NAME <u>FRANCES POLSTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-30-8605</u>		17. INFORMANT <u>BEVERLY QUICKLEY</u> Address <u>ABERDEEN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Fulminating Pneumonia (Bilateral)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Res. Staphylococcus Infection</u> DUE TO (c) <u>Res. Staphylococcus Infection</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>7/30</u> , 19 <u>57</u> , to <u>8/2</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>8/2</u> , 19 <u>57</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George T. Stansbury</u> M.D.				ADDRESS (Street, city or town, state) <u>569 Revolution St., Haver de Grace, Md.</u>			
PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				DATE SIGNED <u>8/3/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-6-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullard - Haver de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>A. L. Lewis M.D.</u>		24b. REGISTRAR'S SIGNATURE	
				DATE <u>8-4-57</u>			

BUREAU V. S.

AUG 8 1917

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
08564 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08572

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abertown</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Ray Roland</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>8-10-38</u>				9. AGE (in years last birthday) <u>19</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labore</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lock Joint Pipe Co</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Leon Roland</u>			
14. MOTHER'S MAIDEN NAME <u>Bertha Johnson</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Leon Roland, Washington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture SKULL, compound</u> <u>910.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Compound fracture both bones R leg</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Pipe mald fell on him</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>August 21, 1957</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Lock Joint Pipe Co</u>				20f. (City or town) (County) (State) <u>Perryman Hartford Md.</u>			
21. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Donald C Palmer</u>				DATE SIGNED <u>8-21-57</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/24/57</u>		<u>Burial</u>		<u>Perryman, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Howard Shaw Md.</u>				24a. REC'D BY REGISTRAR DATE <u>8-22-57</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>	

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item 18. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

BUREAU V. S.

AUG 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08574

CERTIFICATE OF DEATH

08573

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Darlington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Darlington (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rose Middle Belle Last Smith		4. DATE OF DEATH Month August Day 23 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 August 1870
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 8 Days 23 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Hanikson		14. MOTHER'S MAIDEN NAME Harriett Hillis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nathan D. Smith Jr.		Address Darlington, Md. Route #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Generalized Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5-8 yrs (c) Interval between onset and death		INTERVAL BETWEEN ONSET AND DEATH 5-8 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 1956, to August 23, 1957 , that I last saw the deceased alive on August 22, 1957 , and that death occurred at 4:00 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips M.D.		ADDRESS (Street, city or town, state) Darlington, Md. DATE SIGNED 8/24/57	
PHYSICIAN'S NAME (Type) Dudley Phillips M.D.		Darlington, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/57	
22c. NAME OF CEMETERY OR CREMATORY Camptown Memorial		22d. LOCATION (City, town, or county) (State) Camptown, Bradford Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarrington		ADDRESS abertown maryland	
24a. REC'D BY REGISTRAR Aug 26/57		24b. REGISTRAR'S SIGNATURE John G. Tarrington	

BUREAU V. S.

1917

RECEIVED

08565

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Chase		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS Congress		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUSSELL Middle Revel Last STROHM				4. DATE OF DEATH Month August Day 7 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/1907	9. AGE (in years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Strohm				14. MOTHER'S MAIDEN NAME Salitha Jane Hatfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Short Funeral Home, Mt. Carmel, Ill.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. S. Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Funeral		22b. DATE THEREOF 8/9/57		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Mt. Carmel, Ill.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home, Mt. Carmel, Ill.				24a. REC'D BY REGISTRAR 8-9-57		24b. REGISTRAR'S SIGNATURE U. L. Lewis M.D.	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

BUREAU V. S.

AUG 12 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

18 ✓

08575

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin RD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin RD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harriet</u> Middle <u>D</u> Last <u>Striker</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 6 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Daniels</u>				14. MOTHER'S MAIDEN NAME —			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. —		17. INFORMANT Address <u>G. E. Striker, Baldwin MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vremia</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —						INTERVAL BETWEEN ONSET AND DEATH <u>4 weeks</u> <u>3 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1957</u> to <u>present</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 28</u> , 19 <u>57</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest C. Brown Jr.</u>				ADDRESS (Street, city or town, state) <u>1101 N. Calvert St</u>		DATE SIGNED <u>Aug 27, 57</u>	
PHYSICIAN'S NAME (Type) —							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martha E. K. ...</u>				24a. REC'D BY REGISTRAR <u>...</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08566

CERTIFICATE OF DEATH

08576

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE BRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ABERDEEN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>131 N. PHILADELPHIA BLVD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLOTTE ANN STYER</u>				4. DATE OF DEATH Month Day Year <u>AUGUST 11 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 Aug. 1901</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Luther S. McCardell</u>				14. MOTHER'S MAIDEN NAME <u>Cathrine R. Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>131 N. Phila</u> <u>Evelyn M. McFadden Aberdeen, Md. Blvd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>56</u> , to <u>Aug 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>57</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. J. Plunkett Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Aberdeen, Md.</u>		DATE SIGNED <u>8-11-57</u>	
PHYSICIAN'S NAME (Type) <u>B. J. Plunkett Jr.</u>				ADDRESS <u>Aberdeen, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		22d. LOCATION (City, town, or county) (State) <u>R.D. 2 Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Herring</u>				ADDRESS <u>Aberdeen Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>8-13-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

BUREAU V. S.

MAY 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08577

08567

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 608 Revolution Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John William Thompson		4. DATE OF DEATH Month Day Year August 29 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 March 1887
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. APG., Md.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Thompson		14. MOTHER'S MAIDEN NAME Susie E. Cullum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-18-6442	
17. INFORMANT Willie Louise Mitchell-Havre De Grace		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO (b) METASTATIC CARCINOMA DUE TO (c) PROSTATIC CARCINOMA PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 YR.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11 1957 to 8/29 1957 that I last saw the deceased alive on 8/28 1957 , and that death occurred at 5:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Irwin Randall Ross M.D. 200 N. UNION AVE		DATE SIGNED 9-1-57	
PHYSICIAN'S NAME (Type) IRWIN RANDALL ROSS		HAVRE DE GRACE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/2/57	
22c. NAME OF CEMETERY OR CREMATORY Calvary		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tamm		ADDRESS Aberdeen, Md.	
24a. REC'D BY REGISTRAR 9-3-57		24b. REGISTRAR'S SIGNATURE A. R. Remick	

BUREAU V. S.

SEP 4 1954

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08576

CERTIFICATE OF DEATH

08578

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air, R.D.,		c. LENGTH OF STAY IN TB 6 wks.,	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 Darlington		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home	
d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle A. Last Wells		4. DATE OF DEATH Month Aug. Day 16 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28, 1873
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Penna.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Montgomery		14. MOTHER'S MAIDEN NAME Mary E. Garrett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none	
17. INFORMANT Laban Wells, Baltimore		Address 22 Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis - Generalized DUE TO (c) fractured left hip			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fractured left hip			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1957 to Aug 16, 1957 , that I last saw the deceased alive on Aug 10, 1957 , and that death occurred at 12:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dudley Phillips M.D.		ADDRESS (Street, city or town, state) Darlington Md.	
DATE SIGNED Aug 16, 1957		DATE SIGNED Aug 16, 1957	
PHYSICIAN'S NAME (Type) Dudley Phillips		City Darlington Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 18, 1957	22c. NAME OF CEMETERY OR CREMATORY Camp Chapel	22d. LOCATION (City, town, or county) (State) White Marsh, Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McKenney		ADDRESS Darlington, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Franklin Howard	

BUREAU V. S.

AUG 21 1957

RECEIVED

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08568

CERTIFICATE OF DEATH

08579-

Reg. Dist. No. 186-

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harrode-Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS	
3. NAME OF Mary Francis Whitaker (Type or print) First Middle Last		4. DATE OF DEATH Month 8 Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/21/69
9. AGE (In years lost birthday) 88 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham HASSON		14. MOTHER'S M maiden NAME SARAH KELLY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Clarence Whitaker.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 1957 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 1957 to Aug 2-1957 that I last saw the deceased alive on Aug 2 1957 and that death occurred at Port Deposit, Md. from the causes and on the date stated above. SIGNATURE Clarence I. Benson M.D. ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED Aug 2-1957			
PHYSICIAN'S NAME (Type) Clarence I. Benson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/5/57	22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	22d. LOCATION (City, town, or county) (State) Port Deposit, RD, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Keena Patterson ADDRESS Box 188, Perryville, Md.		24a. REC'D BY REGISTRAR 8-4-57	24b. REGISTRAR'S SIGNATURE G. F. Lewis M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[REDACTED]

ASSON

RECEIVED

JUN 6 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 182

08569

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel-Air</u>				c. LENGTH OF STAY IN 1b <u>Lifetime</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R. F. D. #1</u>				d. STREET ADDRESS <u>R. F. D. #1</u>			
3. NAME OF DECEASED (Type or print) <u>E. Ligish</u> First Middle Last				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-1871</u>	
				9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy man</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>George White</u>				14. MOTHER'S MAIDEN NAME <u>Maria</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Effie Morley - Bel-Air Md.</u>				Address <u>R. F. D. #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Prostatism with Urinary Retention</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4/12</u> 19 <u>57</u> , to <u>8/7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>8/7</u> 19 <u>57</u> , and that death occurred at <u>11:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>509 Revolution St., Havre de Grace, Md.</u> DATE SIGNED <u>8/8/57</u> ACTUAL SIGNATURE <u>George J. Stansbury</u> PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clark's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Kalmar, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia L. Bullenk-Havre de Grace</u>				ADDRESS <u>Harford</u>		24a. REC'D BY REGISTRAR <u>W. J. ...</u> DATE <u>8-8-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 thereof, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

AUG 12 1957

FD-36

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08577

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08581
182

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET		c. LENGTH OF STAY IN 1b LIFE	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X1 STREET		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME STREET, MD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle D. Last WILSON SR		4. DATE OF DEATH Month AUGUST Day 29 Year 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 19, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 3 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMMUEL WILSON		14. MOTHER'S MAIDEN NAME JANE MARY DAVIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT SON		Address WIFE SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---		INTERVAL BETWEEN ONSET AND DEATH 3 HRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---	
20c. TIME OF INJURY Month, Day, Year Hour a. m. --- p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) (County) (State) ---
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Philip W. Heuman		DATE SIGNED AUG 29, 1957	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Aug 31/57	22b. DATE THEREOF Aug 31/57	22c. NAME OF CEMETERY OR CREMATORY St. Luke's	22d. LOCATION (City, town, or county) (State) St. Luke's
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hoff		24a. REC'D BY REGISTRAR ---	
ADDRESS ---		24b. REGISTRAR'S SIGNATURE ---	
DATE 8-31-57		24c. REGISTRAR'S SIGNATURE ---	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1957

RECEIVED